KINSTON HEAD AND NECK PHYSICIANS AND SURGEONS, P.A.

PATIENT'S NAME____

Please check correct answers - - - Do you have trouble with?

	NO	YES
1. DIABETES		
2. WEIGHT LOSS		
3. WEIGHT GAIN		
4. FEVER		
5. LOSS OF ENERGY		
6. VISUAL LOSS		
7. DOUBLE VISION		
8. GLAUCOMA		
9. CHEST PAIN		
10. HIGH BLOOD PRESSURE		
11. HEART ATTACK		
12. ASTHMA		
13. SHORTNESS OF BREATH		
14. WHEEZING		
15. COUGH		
16. STOMACH ULCER		
17. HEPATITIS		
18. DIFFICULTY SWALLOWING		
19. VOMITING		

	NO	YES
20. ABDOMINAL PAIN		
21. PROSTATE		
22. BLOOD IN URINE		
23. KIDNEY STONES		
24. ARTHRITIS		
25. MUSCLE WEAKNESS		
26. SKIN RASH		
27. EASY BRUISING		
28. FREE BLEEDING		
29. ANEMIA		
30. ENLARGED LYMPH GLANDS		
31. SEIZURES		
32. DISTURBANCE OF TASTE		
33. DISTURBANCE OF SMELL		
34. HIVES		
35. ECZEMA		
36. HAY FEVER		
37. HIV		

HOSPITALIZATIONS		OPERATIONS		CURRENT MEDICATIONS
Reason	Date	Surgery	Date	

FAMILY:

Father living ❑ Yes ❑ No Cause of Death ____________________

Mother living ❑ Yes ❑ No Cause of Death ____________________

Any hereditary diseases: (free bleeding , diabetes, other)

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SOCIAL:

Married ❑ Single ❑ Divorced ❑

Current Employment ______________________

Do you use: Tobacco ❑ Alcohol ❑

Education ______________________

DRUG ALLERGIES

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I authorize Kinston Head & Neck Physicians & Surgeons, P.A. to furnish information to insurance carriers concerning my illness and treatments. I authorize any insurance payments directly to the physician. I understand that I am responsible for any amount not covered by insurance.

Date:______________________ Signature:______________________

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